

Summary of Country Studies: Private Providers' Contributions to Public Health in Four African Countries

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Background

Four in-country case studies were undertaken in 1994 on the characteristics, growth, and contributions of “private providers” (private and non-government) within the health care service delivery systems in Kenya, Tanzania, Senegal, and Zambia. The major audiences for the subsequent reports are the national Ministry of Health (MOH) in each country and the United States Agency for International Development (USAID), which sponsored the studies. The studies were conducted with the support of the Health and Human Resource Analysis for Africa (HHRAA) Project (Project No. 689-0483) of the USAID Africa Bureau.

The two studies in Kenya and Zambia were done by the Harvard School of Public Health under the Data for Decision Making (DDM) Project (Cooperative Agreement No. DPE. The studies in Senegal and Tanzania

were done by Abt Associates, Inc. under the Health Financing and Sustainability (HFS) Project (Contract No. DPE-5974-2-00-9026-00).

Although there were differences, the studies followed a similar methodological approach in each country. Each study assessed the role of private providers in contributing to the public health agenda of the nations concerned. They focused on: the supply-side, or, services of government and private, for-profit and non-profit practitioners; and, on the demand-side, or, consumers of public and private health services. While the studies were designed to address specific objectives of the research projects involved, they were also undertaken to address the shortage of information on the characteristics of private providers and the health services they provide.

Study Methods

Each study consisted of an extensive literature review of published and unpublished documents from numerous private, academic, government, and donor sources. The review included existing field data and clinical records. Some countries had more data available than others.

Each of the study teams also undertook a field survey of private providers in a small sample of sites. None of the surveys is considered to be fully representative of private providers, but each gives a revealing picture of public and private hospitals, clinics, dispensaries, pharmacies, clinical laboratories, traditional practitioners, and other facilities in each country. Types of service owners included government, modern-for-profit, employer-based, mission-run, and independent

practitioners— both modern and traditional.

Each study discussed: (a) The national economy and health status; (b) Factors contributing to the growth of the private health sector; (c) Private providers' contribution to public health; (d) Factors affecting the supply of and demand for private health care; and (e) Recommendations of strategies for developing public/private linkages to support national health goals.

The purpose of this paper is to summarize the findings and policy implications of the four studies for presentation to participants at an international conference held in Nairobi, Kenya, 28 November to 1 December 1994, entitled: *"Private and Non-government Providers: Partners for Public Health in Africa."*

Characteristics: Who are the Private Providers?

While the evidence varies across the four countries, the studies revealed a general picture of over-burdened public health systems, slowing or stagnating improvement in health status indicators, and increasing government interest in the possible contributions the private sector could make to national health goals.

Type of Providers

In addition to government services, each country has a diverse mix of private providers, ranging from traditional to modern practitioners and from individual and ambulatory practices to large hospitals. The number of different types of providers studied in each country ranged from seven in Senegal to over 20 in Kenya. These can be classified by their for-profit/non-profit commercial orientation and by their type of ownership—for example, individual/group-owned practices, mission/charitable clinics, employer-provided clinics, and others.

Non-Profit

Among the non-profit religious/mission organizations are: Protestant and Catholic hospitals, health centers, clinics, and dispensaries; and mosque-affiliated clinics, dispensaries, and pharmacies. Among other non-profit NGOs are family planning clinics, community health workers, community pharmacies, and other non-profit hospitals.

For-Profit

These providers include individual- and group-run hospitals and clinics with doctors and nurses; privately-owned maternity and nursing homes; employer-provided clinics and pharmacies; and individual pharmacies/chemists, clinical laboratories, stores, shops,

and such traditional practitioners as herbalists, bonesetters, diviners, and birth attendants. Among for-profit facilities and services, a distinction is made between modern and traditional systems of treatment and medicine.

Parastatals and Employer-Based Services

Sometimes these services are in the public sector and sometimes in the private sector. For example, in Zambia, the copper mining companies and other industries which own and operate their own health facilities are mostly government-owned, although their health services often operate quite independently of government; whereas in Kenya such employer-based services are most often in the private sector.

Together these privately provided services are a rather large, and growing, part of the national health delivery systems in each country, particularly in Kenya.

Growth of Private Providers

The growth of private providers has reflected the movement in each nation's economy. For example, in Kenya, the general profile shows (a) relatively few public health services or infrastructure and low health status at the time of independence during the 1960s; (b) a period during the 1960s-70s in which public health expenditures and services increased dramatically and private services only marginally; (c) a period in the 1970s-80s in which the national economy was hard hit.

In a number of countries, a result of weakened economic conditions, employment and income fell, poverty and malnutrition increased, and overall health status worsened. Many of the improving health trends

of earlier years either stagnated or began to be reversed. Some countries have experienced negative changes in immunization coverage, mortality rates, life expectancy, and in the incidence and prevalence of communicable diseases—diarrhoeal diseases, respiratory infections, malaria, and other—as new and old drug-resistant diseases have emerged.

In response to their reduced public health expenditures and the deterioration of health conditions, governments tended, during the 1980s-early 90s, to relax restrictions on the licensing and regulation of private providers and to relax the prohibition on public-sector doctors, nurses, and technicians working part-time (that is, moon-lighting) in private offices, clinics, and hospitals.

In Kenya, for example, the government relaxed restrictions during the 1970s on MOH doctors working in the private sector, then in the 1980s tried to reimpose the restrictions. The result was that many doctors resigned from public service. The government has since permitted MOH doctors, nurses, and clinical officers to work in the private sector. Now, it would not be unusual to find a private dispensary that is owned by a physician who works for the MOH, but

run by a medical assistant or nurse, with the doctor keeping part-time and evening hours.

Today, with public health systems over-burdened and unevenly distributed, governments have new interest in the possible contributions that the private health providers could make to national health goals. The extent of commitment to health reform and the potential role of private providers is different in each country. But, overall, the economic and political environment is now more favorable to the growth of the private health sector than at any time in the past.

For example, Kenya today has a pluralistic health system, because it has permitted a large and diverse private sector to develop. Tanzania has recently, since 1991, eliminated many of its restrictions on the type, size, or location of private providers, with large growth resulting in the private sector. In Zambia, after years of restricting private providers, the government is now committed to major health reform, including new interest in the contribution that the private sector might make to national health goals. And, in Senegal, national estimates are that perhaps six of every 10 doctors work in the private sector.

Services: What do Private Providers do?

The size and distribution of the private health sector in the four countries make it an important part—potentially a much more important part than is generally recognized—of national health care.

In all countries, the government is the largest provider of health services and the biggest spender. The distribution of both public and private services tends mostly to favor urban areas with larger populations, higher formal sector employment, and better ability to pay. However, private providers tend to provide services that meet specific needs for, for example, family planning or oral rehydration. Both the supply of and the demand for services is more for curative than preventive health.

Mission Services

Of all types of private providers, except traditional healers, only missions tend to concentrate their services and facilities in rural areas in order to serve the poor and underserved. In some countries, the mission system of health care is very large and accounts for a high proportion of private hospitals and clinics. Established by foreign missionary groups, the missions' networks developed some years in advance of the more recent development of for-profit providers.

The relationship between government and missions is not uniform across countries. In some countries, government and missions have a rather close relationship, with government providing direct grants for staff and beds to missions. Whatever their relationship with government, church-based providers are important in all countries for reaching rural areas with preventive services.

Employer-Based Services

Some countries require that large employers provide health services for their employees. For example, in Senegal any employer with 100 or more employees must provide health services for them. In Zambia, the copper mining companies, which account for 20-25 percent of national health expenditures, are mostly government parastatals, and their health services are probably the best in the country.

In general, employer-provided services benefit only employees and their families as they are not for the general public. They provide all types of services, but mostly outpatient care through clinics, pharmacies, and specialty laboratories. If the company does not directly provide services to its employees, it purchases such services from private for-profit providers. Except for parastatals, company services may be provided on a fee-for-service basis. Like the for-profit providers (see below), private companies and parastatals tend to concentrate their services in urban areas.

For-Profit Providers

The “modern”, as distinct from traditional, for-profit providers are the fastest growing segment of the private health sector. The growth of the for-profits has been uneven and poorly documented. Clearly, however, their growth and concentration is mostly in the urban areas, where there is a concentrated market, a higher ability of clients to pay, and better access to supplies and transportation. Although there are significant regional variations in each country, more health services and skilled professionals are located in the more accessible areas of higher population concentration and income. For-profit providers provide both

hospital and ambulatory services. However, while the extent of hospital services varies considerably between countries, ambulatory services are significant in all.

As described earlier, many physicians/owners work full-time in public health facilities and part-time in their private clinics or offices. As a group, they are less likely to provide preventive services than are the non-profit NGOs or church-affiliated facilities. While mission services may still outnumber for-profit providers, the missions are typically not expanding while the for-profits are expanding rapidly.

Pharmacists/Drug Stores

In all countries, pharmacies are the largest suppliers of over-the-counter, prescription, and non-prescription medicines. Pharmacies in general are more closely regulated by the government than are other providers. The role of the pharmacy in health care has expanded beyond dispensing medicines. That is, it is not unusual to find “one-stop” pharmacies that provide medical diagnosis, patient counseling, and treatment in addition to dispensing drugs. Like other private providers, pharmacies tend to locate in urban areas.

Traditional Practitioners

These are spiritualists, herbalists, diviners, bonesetters, and traditional birth attendants— all practitioners of traditional medicine, as distinct from “modern” medicine. They often are the most accessible source of health care in rural areas. They, like some pharmacists, tend to be “one-stop” sources of care, providing diagnosis, medicines, and treatment.

There are no reliable estimates of their number or their significance in any country. But, it is known that practitioners, such as TBAs, assist a large proportion of at-home deliveries, especially in rural areas. Recently, governments and donors have started to consider the potential contribution that traditional healers, with modern training, could make to the nation’s health— as bearers of health education messages.

Community-Based Services

In line with governments’ efforts to increase overall health services in rural areas, more community-based and community-owned services are being found in rural places. In Kenya, for example, the number of community-run clinics and pharmacies is growing. The facilities may be managed by a village committee and provide a range of services, such as, dispensing drugs, selling medical supplies, conducting health education, participating in health projects such as immunization or water/sanitation, and treating such illnesses as malaria, diarrhoea, worms, and skin and eye infections. Community-based services may even include a form of health insurance whereby community resources are pooled to help families in the event of catastrophic illness.

In summary, there is a scarcity of information on private services and their use in any country, which makes it difficult to analyse financing or delivery of services. The growth of the private, especially for-profit, sector has been as uneven as it has been rapid. In the absence of good monitoring systems, it is increasingly difficult to track new facilities and the type and quality of their services. There is anecdotal evidence that malpractice is growing.

Determinants: What Factors Affect Their Services?

The four studies looked at supply and demand factors affecting private health services. Supply factors affect the provision of services and demand factors affect people's use of services. Probably the most important demand factors are income and urban/rural place of residence. And the most constraining service supply factors are lack of private providers' access to capital and high government taxes on imported drugs and medical supplies and equipment.

Demand-side Determinants

In all countries, the demand for private services is high. For example, in Kenya, consumers' use of private and mission services is at least 20 percent of total health-care utilization. Adding the purchase of over-the-counter drugs, total modern private-sector use rises to at least 42 percent of total use.

Income

According to both for-profit and non-profit providers, household income is the greatest constraint to the use of their services. And, indeed, where there is evidence of household income, great differences are found in private service use by different economic groups: The poor are most likely to use drug sellers, small individual providers, traditional providers, and mission and mosque facilities; while the more affluent classes are more likely to use larger urban facilities, both public and private.

Education

More educated people are more likely to seek health care and higher-quality care. The higher the level of education, the greater the use of private services. The effect of education on overall health service use is particularly dramatic for mothers. More educated

mothers are more likely than others to seek modern antenatal care and care for children's respiratory infections, fever, and diarrhoea, as well as immunizations. It is assumed that increased health education could increase consumer demand for modern health services, including promoting the use of private services and promoting competition and better services among them.

Residence

Urban areas are more able to support full-time private for-profit services because of economies of scale, generally higher incomes, greater formal sector employment, and better access to transportation. Without any other intervention, there is a greater potential for development in rural areas for the church-based non-profit sector. But being in the poorer areas, the non-profits often have trouble covering their operating costs.

Quality of Services

While cost and proximity are very important reasons for choosing among services, studies find greater patient satisfaction with the "good treatment" of mission and private facilities than with the "poor quality" of government facilities. Some of the reasons that private providers are preferred to public services are because of a cleaner and friendlier environment—for example, good food, good services, better drug supply, better bedding and linen, cleanliness, better trained and more courteous staff, more time with doctors, and shorter waiting times.

Health Insurance

Two countries, Senegal and Kenya, have social insurance schemes. All countries have some form of employer insurance/cost coverage schemes in the

formal employment sector. Insurance tends to promote greater use of private for-profit providers, but insurance coverage is rather limited in each country, and expanding insurance to the informal sector is limited by government resources and difficulties of administration and auditing. Insurance coverage tends to promote increased choice of provider and increased utilization by lowering the cost of care at the time of illness. However, lowering health costs may lead to over-consumption of services and rising costs of insurance over time.

Cost-Sharing

In general, fiscal constraints have reduced government spending for health and are increasing government's reliance on the people to pay more for their own health. One change, at least in Kenya, has been to charge user fees (cost-sharing) for certain public services. This may lead to greater demand for private health care services, and increase competition between private and public providers. Similarly, where government requires large companies to provide their own clinics or pay for employees' health services, the policy may promote growth of employer services and reduce demand for outside for-profit services.

Supply-Side Determinants

MOH services have deteriorated with falling real government funding—drug shortages, lack of essential supplies, over-crowding, and long delays. Despite the difficulty in obtaining financial credit, the economic and political climate in the four countries generally favors the growth of private health services. Governments' legalization or reduced restrictions on private providers have contributed to their expansion in each country. Now, the greatest constraints on providers are lack of access to capital and credit, high taxes on imported drugs and medical equipment and supplies, and lack of trained medical personnel:

Capital

The trend toward more open economic environments has encouraged private sector provision of health services. But where governments have pursued tight money policies to curb inflation and stabilize the economy, one result has been a contraction of bank credit and steep increases in interest rates. There do not appear to be specialized financial institutions that lend to health providers. One result is that private sector growth is dominated by small clinics. Lending to the health sector is not attractive to banks and other financial institutions because of the general lack of collateral and the low liquidation values of such specialty services. Accordingly, private providers are constrained by the high capital outlays for establishing facilities, running day-to-day operations, paying advance rent, paying mal-practice insurance premiums, holding an adequate supply of drugs, and others.

Taxes

Although recently suspended in Senegal, government's high taxes on imported drugs and equipment have restricted private sector development. Moreover, there are no direct government subsidies or incentives for consumers to use private providers. Nor are there subsidies for for-profit providers and only small, if any, subsidies for non-profit providers.

Personnel

With some exception in Kenya and Senegal, there are often notable shortages of doctors, nurses, pharmacists, and technicians. As one example of personnel shortages, Tanzania trains about 40 new doctors each year, while 200 doctors are needed each year. The greatest shortage is in rural areas, as most doctors choose to work in urban areas. It is not known to what extent modern training of traditional healers and birth attendants may offset some of the personnel shortfalls.

In addition to lack of capital, high taxes, and staff shortages, other constraints on private sector development—especially in the rural areas—are high transport costs, low

rural income base, poor rural infrastructure, lack of training facilities, and weak coordination with and little information from the MOH. Overall, government policies and regulations, or their licensing and certification processes, have not constrained the growth of private providers, but have had

the effect of encouraging their urban concentration.

There are three main linkages between the public and private health sectors in the countries studied: (a) laws and regulations; (b) communication and coordination; and (c)

Linkages: What Links Exist Between the Public and Private Sectors?

service delivery. The relationships are not always clear, but public-private collaboration in health care delivery is not new. In particular, the non-profit mission sector has existed for many years in each country, and that relationship with government has generally been sound. Government's relations with the more recently established for-profit providers typically has been less so.

Regulation

From country to country, the laws concerning the private health sector mainly regulate the quality of inputs— such as minimum standards of entry. There are large gaps in the laws affecting private providers, particularly the development of health practices by non-physicians. As a general statement for all four countries, the laws governing the providers' entry into and practice of private health care tend to be enforced weakly and do not have their intended effect. Generally, other than ensuring basic legal requirements, governments have little capacity to assure the quality of medical practice and ensure equitable distribution and access.

Coordination

Typically, the MOH is formally supposed to coordinate public and private health services at the district and province level, but actual coordination often falls short of intentions. In Zambia, for example, there are few fora by which private providers have any direct communication or input into national health policy.

Service Delivery

Both public and private health services tend to be more

curative than preventive. As such, both systems are generally trying to deliver the same types of services. However, the non-profit mission sector offers services that deliberately try to reach rural areas with preventive health care. Data on Zambia and Kenya show a rather active private sector involvement in the treatment of priority national health problems.

In Zambia and Kenya, private providers, including missions and other NGOs, make a major contribution to the supply of family planning services. Many types of private providers are involved: hospital, clinics, for-profit providers, donor-assisted projects, national associations, employer-provider services, pharmacies, shops, and others. Private providers are sometimes more important suppliers than public providers for certain contraceptives, especially condoms.

For numerous public health problems, private providers make varying contributions. Children's common infectious diseases, such as diarrhoea and respiratory infections, are often taken to private providers or sources of pharmaceuticals for self-treatment. Private providers contribute to the public health agenda by giving immunizations, assisting deliveries, treating malaria, treating sexually-transmitted diseases and tuberculosis. Their clientele and their services vary by type of provider (say, missions vs. a nurse's outpatient practice vs. drug sellers) and their rural, small town, and urban locations.

Implications: What are the Opportunities for Improving Public Health and Private Provision?

Each of the studies seeks to document the contribution of private providers to national and public health goals. The studies also recommend ways of improving public/private collaboration to identify national health priorities and to undertake joint actions to achieve them. But, in the four countries, the absence of comprehensive information limits the assessment of the role of private providers and their potential for improving public health. It is known, however, that private providers are not heterogeneous in structure, fees, composition, output, or location. They also vary in their susceptibility to government leverage. Because of the wide variety of private providers, policies to enhance support for national health goals must be tailored to the needs of each type of provider.

Some general tendencies are found across the four countries. Overall, budget allocations for public health systems are declining and the systems are struggling to provide equitable access to care and prevent deterioration of national health status. Both private and public services are heavily concentrated in urban areas. Public health decision-making is over-centralized and slow to respond effectively to health needs. Communication and coordination of public and private services are both weak. The private sector has little opportunity to contribute to public health policy.

The improvement of health service delivery, reach, and impact will require some higher level of policy dialogue, as well as programming collaboration with private providers. Immediate and mutual public- and private-sector concerns are: (a) Increasing available health resources; (b) Increasing efficiency of resource use; (c) Increasing equity of access; and (d) Increasing effectiveness of services.

To increase the quantity and quality of private providers' contributions to public health requires that governments reduce constraints on private providers' services and improve monitoring and coordination of those services.

Steps might include continued decentralization of health decision-making, improved information-sharing, improved modern medical training, relaxed restrictions on public health professionals working in the private sector, and other reforms.

The central problem for governments is to recognize people's demand for health services and to attempt to meet that demand through any conventional or unconventional means—pharmacies, traditional healers, birth attendants, community-based services—that effectively reaches and appeals to people where they live. In short, the improvement of national health status requires governments to use more effectively the health services that are already in place. For example, there are many reasons why a TBA or local pharmacist, with proper training, can be a useful part of a national health referral system.

Some implications that may have general application to all or most of the countries are as follows:

Rural Areas

Most providers prefer to work in the urban areas where there is a larger client base and a better ability to pay. Government will probably have to develop tax breaks, subsidies, or other financial incentives to improve the equitable distribution of private health care in rural areas. Such incentives can include subsidies for start-up costs, modification of licensing rules and regulations, and providing such public resources as seconded government staff to private facilities. Encouraging the development of better and wider rural health services may also entail rural residency requirements for medical school graduates.

Missions

A strong opportunity for the private sector to contribute to national health goals is through non-profit providers,

especially church-based services. New services can build on the already-existing mission and charitable health structures. In all the countries, the charitable sector has an extensive rural network of curative and preventive services. Governments can strengthen the reach and quality of mission services in rural and poor areas through staffing incentives and an improved grant scheme—beds, staff, facilities, equipment—for service in such areas.

For-profits

Continued private for-profit sector development is most likely to reinforce already existing biases toward concentration in urban areas and service provision to higher income groups. Through various economic incentives, reduced drug and equipment taxes, loan guarantees, apprenticeship requirements, and/or regulatory relaxation, governments could influence private sector growth in the underserved rural areas. For example, governments could consider revising strong licensing requirements for physician-run clinics.

Employer-based Services

The strength of the health sector in many countries depends on the economic growth and viability of private enterprise. While governments lack the capability to mandate expansion of health services in the informal employment sector, they could consider new approaches to contract employers to extend their services to non-employees and to underserved areas of the country through grants, social insurance, reduced supply and equipment prices, loan guarantees, and tax relief.

Pharmacies

Governments need to recognize that pharmacies are increasingly important, “one-stop” sources of health care services. Also, pharmacies may be more likely to locate in smaller urban centers than many other fixed-site health facilities. Health care delivery program models should incorporate and build on user-patterns for pharmacies and integrate them into preventive and low-curative outpatient programs. Along with better information and training, governments could ensure that pharmacies providing care

should have a clinically trained pharmacist, doctor, nurse, or other clinical officer on site.

Traditional Practitioners

Training medical school students in traditional health practices might improve the effectiveness of their treatment skills; and training traditional practitioners in modern health practices may extend services that are otherwise unavailable to rural areas—for example, training of TBAs in improved maternal and perinatal care or incentives for traditional healers’ participation in immunization and other preventive programs. New lines of communication and feedback with traditional practitioners should be developed, inasmuch as governments can take advantage of some of the organized elements of traditional medicine.

Health Insurance

Governments’ on-going reform strategies should produce better benefits for members, improve service quality, and reduce costs for hospitals. Social and Private insurance can play a role with improved laws and limiting subsidies, tax exemptions, or tax deductions. With improved insurance schemes, the growth and effectiveness of the private provision sector can be stimulated and enable governments to divert resources to deprived rural areas, thus increasing both the level of private provision and the availability and equity of public services.

Information and Coordination

Governments should enforce licensing requirements and tie license applications to improve data reporting. More information is needed about the cost-effectiveness of, and the kinds of incentives needed for, integrating small private providers and traditional practitioners into immunization and other preventive health care programs.

All reports recommend that governments and donors recognize the current and potential importance of private providers in health care delivery. One useful

suggestion that may fit all countries is that planners develop specific models of public/private collaboration based on specific health problems, types of providers, geographic locations, target populations, fees paid, insurance coverage, and types of services—disease treatment, referral, preventive care, and health information. Such models should make explicit the costs and benefits of improved integration of private and public delivery of family planning services, immunization programs, and treatment of diarrhoeal diseases, respiratory infections, and other conditions affecting the public's health.

Summary of Case Studies:

Kenya

Senegal

Tanzania

Zambia

Kenya: Private Providers and Public Health

Background

This summary is based on the DDM working paper entitled, Kenya: Non-Governmental Health Care Provision by Peter Berman, Kasirim Nwuke, Kara Hanson, Muthoni Kariuki, Karanja Mbugua, Sam Ongayo and Tom Omurwa. Please see original report for complete details. The study conducted by DDM is an assessment of the role of “private providers” (private and non-government) in health delivery. On the supply-side, the study focused on private practitioners and government. The demand-side focused on consumers. As in Zambia, the study was done in part to address the lack of information on the characteristics of private providers and the health services they provide.

Study Methods

The 1994 study was a literature review of over 45 published and unpublished documents from numerous private, academic, government, and donor sources, including existing field data and clinical records. The study team also undertook a field survey of 194 private providers in four sites: 107 modern providers, 52 pharmacists/chemists, and 35 traditional healers.

The study focused on: (a) Kenya’s economy and health status; (b) private providers’ contribution to public health; (c) factors affecting the supply of and demand for private health care; and (d) recommended strategies for developing public/private linkages to support national health goals.

Characteristics: Who are the Private Providers?

Kenya’s post-independence history shows: rapid growth in the 1960s-70s; measurable growth in the 1980s; and economic stagnation in the 1990s. Over the years, Kenya’s early economic achievements have been weakened as a result of the oil price shocks during the 1970s, declining exports, droughts, political instability, uncertain donor support, and economic policy failure. Accordingly, many of its early health improvements—such as declining mortality, increasing life expectancy—have stagnated and others are on the verge of being reversed.

The country has a pluralistic health system, allowing a large and diverse private health sector to develop. The government has promoted an environment conducive to greater private sector involvement in all sectors of the economy, including few restrictions on private health services.

As such, in a relatively brief time, 1960s-1990s, the total number of hospitals more than doubled to 308 and the number of health centers more than tripled to 569 by 1993.

However, fiscal constraints reduced government spending for health and increased its reliance on the people to pay more for their own health care. One change has been to charge user fees (cost-sharing) for certain public services. This may lead to greater demand for private health care. Private providers are a large part of Kenya’s health care provision. They account for about 50 percent of all hospitals, 36 percent of hospital beds, 21 percent of health centers, and 51 percent of other outpatient treatment facilities. There is some confusion about the classification of private providers. This study classified them by

commercial orientation and type of ownership:

- Among the non-profit religious/mission organizations are: Protestant and Catholic hospitals, health centers, clinics, and dispensaries; and mosque-affiliated clinics, dispensaries, and pharmacies. Among other non-profit NGOs are family planning clinics, community health workers, community pharmacies, and other non-profit hospitals.
- The for-profit providers include individual- and group-run hospitals and clinics with doctors, nurses, and technicians; employer-provided (including parastatal) clinics and pharmacies; and individual pharmacies/chemists, clinical laboratories, stores and shops, including such traditional practitioners as herbalists, bonesetters, diviners, and birth attendants. Moreover, maternity and nursing homes are mostly in the for-profit sector.

The government is the biggest health-care spender -- about 42 percent in recent years of recurrent health expenditures--and the largest provider of health services. However, the private sector is increasingly important. Some factors that aided the rapid growth of private providers are (a) the government's decision in the 1970s to permit public employees to engage in private practice; (b) the government's attempt to withdraw the privilege in the 1980s, which caused many doctors to resign from government; (c) the government's decision in 1989 to permit nurses and clinical officers to engage in private practice--which especially encouraged the growth of clinical laboratories, medical centers, dispensaries, health clinics; (d) the increase in national health insurance reimbursement rates; and (e) deteriorating job conditions and job satisfaction in the public sector.

Services: What do Private Providers do?

The public sector health system is organized as a pyramid system of facilities in each of the country's eight administrative provinces. Kenyatta National Hospital is the top of the pyramid with curative and

specialty inpatient and outpatient services. Provincial and district hospitals are in the middle providing both curative inpatient and outpatient services. Rural health centers, dispensaries, and mobile clinics are the base of the pyramid providing some outpatient curative services but mostly preventive and primary care services. To bring public and private services together, a MOH officer in each province and in each district oversees and coordinates public and private services.

As of this year, there are 1446 private health facilities in the country. Roughly one-half are mission-run (47%) and one-half are private/employer-provided (51%). The rest (about 2%) are owned by the Family Planning Association of Kenya. Each type of owner pursues different objectives: for-profits want to maximize profits; companies want to reduce production losses from ill workers; and missions want to fulfill a philanthropic purpose-missions.

The location of services is affected by many factors: existing infrastructure, size of market, ability to pay, availability of supplies and factors of production. In general, religious-owned services tend toward rural locations and company-owned and for-profit facilities tend toward urban locations. There are significant regional variations. For example, two provinces have more than one-half of all private hospitals; and half of all doctors who went into private practice in recent years have set up in Nairobi. The following are some key private services:

Mission Services

The mission sector owns over 680 private health facilities. Protestant groups have 230 facilities, Catholic groups have 354 facilities, and mosques run 12 facilities. Together, they account for two-thirds (68%) of the private hospitals, over four-fifths (87%) of the health centers, and about two-fifths (43%) of other health facilities. Mission services are located mostly in rural, largely Christian areas. Thus, while non-Christian areas are underserved by good-quality mission services, the missions in general promote

equity of access to rural Kenyans. Mosque-affiliated services are all in urban Moslem areas. Overall, mission services rely on cash payments, some government grants, employer reimbursements, and insurance payments for inpatient services.

Private/Company-run Services

These include employers, sole proprietors, partnerships and groups, as well as parastatals. They provide all forms of services, but mostly outpatient services through clinics, pharmacies, and clinical laboratories. Except for parastatals, these run on a fee-for-service basis. There are over 730 private/company facilities, of which a third (32%) are hospitals, a few are health centers (13%), and over half (55%) are other facilities. If employers do not provide their own services, they buy services from private providers.

Pharmacies/Chemists

These are important sources of care because so much of household health spending is on self-care medicines. There are three important features of pharmacies. First, of the 290 pharmacies and chemists, about one-half are in Nairobi, and nearly three-fourths (71%) are located in three provinces. Other shops, drug stores, and vendors are widely dispersed across the country. Second, many operate as one-stop health providers. They provide diagnosis, counseling, and medicines. This tendency toward diagnosing illnesses is increasing rapidly. Third, many are community-operated facilities. They are the result of government's policy to increase overall health services in rural areas at low cost and high access. They are managed by a village committee and do many things: dispense drugs, sell medical supplies, conduct health education, participate in water/sanitation and immunization projects, and treat common illnesses such as malaria, diarrhoea, worms, and eye and skin infections.

Traditional Practitioners

There are no firm estimates of the number of traditional healers, herbalists, bonesetters, and diviners in the country. They are widely available in the rural areas, often the most accessible source of health care. They operate on a sliding scale of fee-for-service, depending on patients' economic status. Their clientele is generally older people. There are some 7,953 traditional birth attendants in Kenya, who assist about one-fifth of all births. The majority are untrained.

Determinants: What factors Affect Their Services?

The study looked at supply and demand factors affecting private health services. Supply factors affect the types and provision of services, while demand factors affect people's use of services.

Demand-Side Determinants

The demand for private services is high. For example, use of private and mission services is at least 20 percent of total utilization. Adding in the purchase of over-the-counter drugs, total modern private-sector use rises to at least 42 percent of total use. The most common sources of inpatient care are private hospitals (36%), government hospitals (27%), and mission hospitals (22%). There are great differences in private service use by different economic groups: the poor are most likely to use drug sellers, small individual providers, and mission and mosque facilities; while the large urban facilities serve more of the affluent classes.

Age and Gender

Women are somewhat more likely than men to use private for-profit services, possibly because more men are covered by employer services. And, apparently, older people are more prone to use traditional healers than younger people.

Income and Education

There is evidence that private and mission services are an important source of care for the poor. Still, when education is used as a proxy for income, it is found that better educated people are more likely to seek health care and more likely to seek higher-quality care. The higher the education, the greater the use of private services. The effect of education on overall health service use is particularly dramatic for mothers. Better educated mothers are more likely than others to seek modern antenatal care and care for children's respiratory infections, fever, diarrhoea, as well as immunizations.

Health Insurance

The national hospital insurance fund covers inpatient care in both public and private facilities, and serves about 6 million people. Like other insurance schemes, it has promoted increased consumers' demand and health-care choices by lowering the cost of care at the time of illness. This has probably increased the use of private facilities. However, lowering health costs may be leading to over-consumption of services and increasing costs of insurance in Kenya. The public system is financed by graduated contributions from workers' monthly incomes. After the government introduced cost-sharing, all kinds of government and private facilities have sought to increase their revenues from the insurance scheme.

A second type of insurance is private insurance taken out by individuals or employers for their employees. There is no estimate of the number of persons covered, but most clients are in urban areas and employed in the formal sector. A third, informal type of insurance, the "Harambee" movement, is provided by communities that voluntarily pool their funds for assisting families facing catastrophic illness.

Quality of Services

While cost and proximity are the most important reasons for choosing among services, studies find greater patient satisfaction with mission and private facilities than with government facilities. Some of the other reasons that private providers are preferred to public services are because of a

cleaner environment, good food, good services, better drug supply, better bedding and linen, cleanliness, and shorter waiting time. The government's introduction of cost-sharing will probably further increase private-sector demand.

Supply-Side Determinants

MOH services have deteriorated with falling real government funding leading to drug shortages, lack of essential supplies, sub-standard facilities, over-crowding, and long delays. Despite the illiquidity of the financial market, the economic and political climate favors the growth of private health services. The greatest constraints on them are the lack of access to capital and credit and high taxes on imported drugs and medical supplies.

Capital

Kenya's open economic environment has encouraged private sector provision of health services. But during the past year, the government has pursued a tight money policy to curb inflation and stabilize the economy. This resulted in a contraction of bank credit and steep interest rates. Moreover, private providers are constrained by the high capital outlays for establishing facilities, running day-to-day operations, one-year's advance rent, high malpractice insurance costs, holding an adequate supply of drugs, and others. There is no specialized financial institution that lends to health providers. Lending to the health sector is not attractive to banks and other financial institutions because of the general lack of collateral and the low liquidation value of such specialty services.

In addition to high taxes, other constraints are high transport costs, low rural income base, poor rural infrastructure, lack of training facilities, and little information from the MOH. The general effect is to push private providers toward urban locations.

Linkages: What Links do They Have With the Public Sector?

Of every 10 such facilities or beds, five hospitals are private, about four beds are private, two health centers are private, and five other treatment facilities are private. MOH officials are supposed to coordinate public and private health services at the level of the district and the province. Kenyan laws concerning the private health sector mainly regulate the quality of input, for example, minimum standards of entry. There are large gaps in the laws affecting private providers, particularly the development of health practices by non-physicians. Reportedly, the laws are poorly enforced and do not have the desired effect.

Many types of private providers are involved in family planning programs: hospitals, clinics, for-profit providers, donor-assisted projects, a national association, employer-provided services, pharmacies, shops, and others. Private providers are more important suppliers than public providers for IUDs, female sterilization, and condoms. In addition, some 45-60 percent of illness episodes are treated by private providers. For numerous public health problems, private providers make varying contributions. Children's common infectious diseases, such as diarrhoea and respiratory infections, are often taken to private providers or sources of pharmaceuticals for self-treatment. Private providers contribute to the public health agenda by giving immunizations, assisting deliveries, treating malaria, treating sexually-transmitted diseases and TB. Their clientele and their services vary by type of provider (e.g., missions vs. a nurse's outpatient practice vs. drug sellers) and their rural, small town, and urban locations.

At present, there are few explicit linkages between government and private providers. Consultations occur with professional associations on an episodic basis.

Implications: What are the Opportunities for Improving Public Health and Private Provision?

This study documents the contribution of private providers to Kenya's health goals, and recommends ways of improving public/private collaboration to identify national health priorities and to undertake joint actions to achieve them. It cautions that, because of the wide variety of private providers, policies to enhance support for national health goals must be tailored to the needs of each type of provider. Recommendations are given in three categories, with better research data, training, and monitoring and reporting common to all categories. Some key recommendations are:

General Policies

The on-going reforms of the Kenyan economy are intended to promote private sector growth, including the health sector. The challenge to government is to strengthen the private health sector within the general reform strategies of financial deregulation, lower interest rates, and to encourage private provider competition through cost-sharing in public facilities. Also, the government should find incentives to improve the equity of private health service coverage in rural areas, such as subsidies for start-up costs, modification of licensing rules and regulations, and providing such public resources as seconded government staff to private facilities.

Specific Providers

Different actions are needed for different providers, for example: (a) Missions: The government can strengthen the reach and quality of mission services in rural and poor areas through staffing incentives and an improved grant scheme for service in such areas; (b) For-profits: Government could consider revising its strong licensing requirements for physician-run clinics and perhaps lower the cost of malpractice insurance; (c) Insurance: Government's on-going reforms should

produce better benefits for members and improve the incentives for service quality and efficiency in hospitals; (d) Pharmacies: The MOH should recognize that pharmacies are increasingly an important source of health care and ensure that pharmacies providing care have a clinically trained pharmacist or doctor, nurse, or clinical officer; and (f) Traditional Practitioners: Training of medical school students in traditional healing practices might improve the effectiveness of their treatment skills.

Specific Services

The report concludes with recommendations for specific health problems. For example, “modern” training of TBAs for maternal and perinatal care; better integration of private and public family planning services; study of the cost-effectiveness of integrating small private providers into

immunization programs; better information and incentives to improve private providers’ treatment of TB, malaria, diarrheal diseases, and other illnesses.

The report comments frequently on the need for government and donors to recognize the importance of private providers in health care delivery. It suggests that a useful approach would be to develop specific models of public/private collaboration based on specific health problems, types of providers, geographic locations, target populations, and types of services-disease treatment, referral, preventive care, and health information.

Senegal: Private Providers and Public Health

Background

This summary is based on the Abt Associates/HFS Project's Major Applied Research Paper No. 16, The Private Sector Delivery of Health Care: Senegal, by James Knowles, Abdo Yasbeck, Steven Brewster and Bineta Ba. Please see original document for complete details. Abt Associates (under the HFS project) conducted a study in Senegal on public and private providers in 1994 which relied extensively on secondary sources of information available from existing reports, analyses, government statistics, and surveys. Abt also conducted a qualitative survey in April-May 1994 of 57 private sector facilities, four types of firms and parastatals, private-for-profit providers, and other providers.

The study focused on private sector development in Senegal, specifically: (a) the private sector's growth and contribution to public health; (b) government's relationship to private providers; and (c) possible areas for private-public collaboration.

Study Methods

The 1994 study included an in-country review of published and unpublished documents from 20 private, government, and donor sources; visits to 70 private facilities in Dakar and rural areas; and in-depth interviews with a wide range of 60 owners/managers of different types of health facilities.

A series of open-ended questions was asked on: 1) problems encountered in starting up a private practice; 2) factors influencing the private sector; 3) provider suggestions for government policies to promote the private health sector and to strengthen its role in providing public health services; and, 4) provider attitudes toward traditional healers.

Characteristics: Who are the Private Providers?

Seven types of non-governmental providers were studied, including: private for-profit and church-owned non-profit hospitals, clinics, and dispensaries; employee-based clinics and hospitals; privately-owned diagnostic centers and pharmacies, dentists, and traditional healers.

The size and distribution of the private sector throughout Senegal make it an important part of health-care delivery in the country. Private providers are a mix of (a) for-profit providers serving urban high- and middle-income groups and charging relatively high fees, and (b) non-profit, mostly church-run facilities serving rural and poor populations and charging no or nominal fees. Company clinics are also important—by law, any employer with 100 or more employees must provide medical services for them.

Private Doctors

Data on private doctors (roughly 231) are not up-to-date. Estimates are that, nationally, about six of every 10 doctors, as compared with one of every 10 nurses and other paramedicals, work in the private sector. Of every 10 doctors, eight work in Dakar, nine work in small medical offices, and four are specialists. Almost all specialists (96%) work in Dakar while fewer generalists (71%) are in Dakar. Of those who work for institutions, virtually all specialists, but only about one-half of the generalists, work for for-profit clinics.

Workplace Facilities

In Senegal, employers with 100 or more employees must provide medical services for their employees. Companies with 450 or more employees are required to retain the

services of a permanent physician. In addition, many employers provide health services to their employees through on-site clinics. Among the private and parastatal employers providing health services are the mining industry, the sugar company, the electric company, the water company, the public bus company and the postal service.

For-Profit Providers

For-profit health provision is limited to individual and private practitioners and small clinics, located mostly in urban areas and providing curative care. In 1991, there were 25 private polyclinics providing ambulatory care, general hospitalization, and obstetrical care, 19 of which were located in Dakar. In addition, there were 47 private for-profit health posts and 32 infirmaries, many of which are owned and operated by nurses and nurse-midwives. In 1989 there were 150 physicians and 16 nurse-midwives in private practice, about three-fourths of whom practiced in Dakar, with most of the rest in St. Louis and Thiès.

Non-Governmental Organizations

Of the 659 health posts in Senegal, 85 are run by NGOs, 68 of which are Catholic. The Red Cross operates 13 medico-social centers, and the Association Sénégalaise pour le Bien-Etre Familial (ASBEF) operates two family planning clinics in Dakar and Louga. In addition, there is one truly private non-profit hospital. These NGO services together have been estimated to cover only 5 to 10 percent of the population.

Mission Facilities

The 68 Catholic Church health posts, which tend to be larger and better staffed than most NGO facilities, are located primarily in rural areas. Although they account for only 10 percent of health posts, they provided an estimated 40 percent of all visits to health posts in 1988.

Private Pharmacies

The private pharmaceutical sector in Senegal consists of three local pharmaceutical manufacturing companies which

collectively supply about 10 percent of the pharmaceuticals consumed in the country. Although the private pharmaceutical distribution system functions fairly well, it is heavily concentrated in urban areas.

The Government of Senegal (GOS) controls the location of pharmacies through its licensing procedures. Retail margins are also controlled by the GOS, and they are lower for certain essential drugs thereby reducing retailers' incentive to stock those drugs. To contain rising prices, the GOS has intervened by negotiating a 10 percent reduction in producer prices by suspending import duties and other taxes on pharmaceuticals, and by reducing the maximum allowable wholesale and retail margins. Although these measures succeeded in containing price increases, it is clear that the devaluation adversely affected prices and incomes, as well as the demand for pharmaceutical products. In addition, due to the expanding "black market", the quantity of drugs sold illegally is greater than that sold legally by the public health system.

Traditional Healers

Traditional practitioners, both healers and birth attendants, are an important component of Senegal's private health sector. A recent estimate of the number of traditional healers is 5,500 through the country. It is estimated that 90 percent of the Senegalese population use the services of a traditional practitioner at one time or another because they are more accessible, affordable and culturally acceptable than modern practitioners. Although not in any way regulated by the GOS, traditional practitioners represent a potentially valuable resource in such areas as distribution of contraceptives and ORS, as well as in the prevention and treatment of sexually transmitted diseases.

Services: What do Private Providers do?

In Senegal, the private sector plays only a limited role in providing public health services. Although non-profit private sector facilities typically provide a full range of preventive services (with the exception of Catholic health posts which do not provide contraceptives), these facilities tend to

provide less preventative care than curative care. According to the Abt survey, preventive visits accounted for 11 percent of all visits in Catholic health posts, but for 33-34 percent of all outpatient visits in public health centers and health posts. For six of the private for-profit facilities surveyed, vaccinations were the only preventive service offered, accounting for only 8 percent of all outpatient visits.

One constraint to the provision of private health services in Senegal is that most of the rural population has no access to private facilities other than drug posts. Also, private physicians have focused primarily on curative care and provide high-priced services to a small segment of the population. Some private physicians said that preventive care was the sole responsibility of the government. A larger number of physicians suggested that the government subsidize the provision of preventive services in one way or another.

Determinants: What factors Affect Their Services?

The study looked at supply and demand factors affecting services. Supply factors affect the types and provision of services; and demand factors affect people's use of services. Demand was largely inferred from interviews with providers.

Demand-Side Determinants

Poor general economic conditions seriously limit demand for private for-profit health services and even, to some extent, for lower-priced services from non-profit providers. In particular, the recent devaluation has had a severe impact on the standard of living of the middle and upper classes, who are the traditional clientele of for-profit private health services.

Income

According to both for-profit and non-profit providers, low per capita income is the greatest constraint to the use of their services.

Fifteen of 57 respondents to the provider survey mentioned that deteriorating economic conditions, particularly after the devaluation, had an enormous negative effect on their practices and/or business. Patients were no longer able to afford their services, insurance companies were insolvent, companies were closing, and the price of medications had increased significantly. One respondent observed that people were moving increasingly to traditional practitioners for health care. It is possible that current economic conditions may not permit the existing private health sector to survive, let alone expand its contribution to the public health agenda.

Employment

The limited size of the salaried work force effectively constrains the growth of both private and social insurance, an important potential source of demand for private sector services. It also limits the potential for the population to benefit from workplace-provided services.

Insurance

Health insurance coverage is currently limited to about 10 percent of the population, mostly residents of Dakar. Nevertheless, such coverage is an important determinant of the demand for private for-profit health services. The fact that the size of the salaried work force has actually decreased in recent years has limited the growth of health insurance coverage and the demand for for-profit health services. Reform of the insurance system has the potential to increase coverage dramatically.

Perceptions

As in Tanzania, people perceive government services to be of lower quality and private services to be of better quality. In general, patients surveyed were satisfied with the services they received in both public and private facilities. At private sector facilities, well over 90 percent of patients expressed general satisfaction with the quality of care and said that they would come back.

Staff members in private facilities tended to rate the quality of care in their facilities as “good”. Staff perceptions were most favorable in for-profit facilities (93 percent) but were also high at workplace clinics and Catholic health posts (74 and 79 percent respectively). The exception among private facilities was other non-profit clinics, where only 26 percent of staff members rated the quality of care as “good”. The highest rating among government facilities were for health posts (33 percent).

Other Factors

The survey revealed other constraints to the demand for services. Problems of physical and financial access were cited as the most important obstacle by over 60 percent of respondents. A smaller percentage (16.5 percent) of respondents cited quality-related problems.

Supply-Side Determinants

For both for-profit and non-profit providers, the lack of credit is the greatest constraint to starting or expanding their medical services. Nearly half of the respondents to the provider survey complained about problems they encountered in seeking start-up financing. When they were able to secure financing, they often complained about the high interest rates. The fact that so many physicians mentioned credit as a constraint suggests that providing better access to credit might be an inducement for some physicians to relocate outside of Dakar. Some part of their loans could be forgiven based on the volume of preventive care they subsequently provide.

Severe Constraints

Other major constraints to private sector growth are: taxes and import duties; drug price controls; and location restrictions for health care providers. Almost all respondents to the survey lamented the high taxes they had to pay; the corporate tax rate is 35 percent, and the maximum personal income tax rate is 50 percent. High import duties on medical equipment are an important impediment to establishing private practices. Selective tax concessions might be used as a policy instrument to affect location

decisions, as well as the proportion of practice activity devoted to preventive care. The two-tiered system of drug price controls seriously limits the retail profit margin on these products, leading to stock-outs and a lack of interest among distributors in carrying the products. As mentioned previously, the GOS enforces location restrictions in licensing health care providers, particularly physicians and pharmacists.

Linkages: What Links do They Have With the Public Sector?

In Senegal, numerous measures taken by the public sector affect the private health sector, including: 1) subsidies to private providers; 2) taxes and price controls; 3) direct provision and regulation of health insurance; and 4) restrictions on competition and other forms of legal and regulatory controls.

The government has begun collaborating with the private sector to improve health service delivery. There is already some effective collaboration between the Ministry of Public Health and Social Action (MOPHSA) and non-profit providers, such as the secondment of some government staff to work in Catholic health posts. The GOS subsidizes the training of health workers and partially reimburses the health care expenses of civil servants, which strengthens demand for private health services. Through suspension of all taxes on the pharmaceutical sector, the GOS in effect subsidizes the pharmaceutical sector of about 25 percent of retail prices. There have also been attempts in a number of projects to integrate traditional health workers into the modern health system. The GOS also appears to work closely with professional associations (e.g., of physicians and pharmacists) to regulate market supply.

Implications: What are the Opportunities for Improving Public Health and Private Provision?

The MOPHSA in Senegal could clearly benefit from increased participation on the part of the private sector in the country's public health system. To achieve that, the MOPHSA may want to identify the potential private sector contribution and to develop suitable strategic plans to make the private sector role explicit. The recommendations to promote private sector development are:

- provide a favorable policy environment;
- stimulate the growth of health insurance;
- promote hospital cost recovery;
- subsidize the private provision of preventive health services;
- expand the availability of credit; and
- examine taxes and import duties.

The MOH could also seek to provide a stable regulatory environment in order to eliminate as much uncer-

tainty as possible from the business environment. They could also maintain a continual dialogue with private providers, insurers, and pharmaceutical producers and distributors in order to cement closer working relationships.

Tanzania: Private Providers and Public Health

Background

This summary is based on the Abt Associates/HFS Project's Major Applied Research Paper No. 14, Private Sector Delivery of Health Care in Tanzania by Abdo Yasbeck, Denise DeRoeck, and Denise Lionetti. Please see the original document for complete details. The purpose of this study by HFS/Abt Associates was to provide baseline information and analysis that the Ministry of Health (MOH) in Tanzania could use to develop policies that will enhance public-private health sector partnerships to improve health coverage, strengthen quality and efficiency of health services, and improve health status. Specific objectives were to:

- Describe the size and scope of the private sector in health care delivery in Tanzania and assess the actual and potential role of the private sector in promoting the public health agenda;
- Describe the current linkages between the public and private sectors in health care and identify areas where collaboration has the potential to improve health services delivery; and,
- Identify factors that affect development of the private sector in Tanzania, especially legal, regulatory, tax and financial matters.

Study Methods

This study relied extensively on secondary sources of information, available from existing reports, analyses, government statistics, and surveys. The field research team, composed of Tanzanian and HFS/Abt staff researchers, also conducted a large number of field interviews, a random sample survey of 61

private providers, and interviews with patients in Dar-es-Salaam and Kilimanjaro. The interview survey did not cover the informal health sector, including traditional health providers and birth attendants, because of the inability to establish a sampling frame for that category.

Characteristics: Who are the Private Providers?

This study identified three major types of private sector providers currently operating in Tanzania as classified by ownership and financial orientation: non-profit voluntary agency facilities, employer-based facilities, and for-profit health care providers. Leaving the traditional sector aside for practical reasons, the study also identified five subcategories of private sector providers:

- 1) non-profit providers run by voluntary agencies and designated as "approved organizations";
- 2) employer-based private and parastatal providers;
- 3) for-profit providers affiliated with "approved organizations";
- 4) for-profit providers approved prior to 1991; and,
- 5) all other independently-owned for-profit health providers approved since 1991.

Non-profit private sector providers, primarily church-based and voluntary agency health facilities have historically played a large role in Tanzania. Voluntary agencies owned 44 percent of the nation's hospitals registered in 1993 and nearly half of all hospital beds. Included in these totals are the "Designated District Hospitals" (DDHs) -- 17 hospitals owned by non-

profit voluntary agencies that the MOH incorporated into its health network shortly after independence in 1961. Although the DDHs are still owned by the voluntary agencies, they are now fully funded and directed by the MOH and are now generally considered to be public facilities.

One of the cornerstones of the government's current health sector reform efforts is to encourage private sector development in ways that can complement the government's provision of health services. The change in posture toward the private sector has its roots in a recognition of current public sector financial constraints which make it necessary to look to non-governmental sources of health care, as well as in a changing political environment. Liberalization of the laws concerning private providers has caused an explosion of independently-owned for-profit facilities, which now account for 42 percent of all private facilities in Dar-es-Salaam, including 83 percent of all private hospitals and 57 percent of all privately-owned hospital beds.

Services: What do Private Providers do?

While the public sector provides a majority of health care services, especially preventive, the private sector contributes significantly to health care delivery in Tanzania.

In general, the private hospitals and health centers are much more likely to provide priority public health services than the many dispensaries. In the provider interviews conducted for the study, 50 percent of the voluntary agency facilities said that they offer a list of preventive services, compared to only 21 percent of for-profit facilities. Preventive services included health education activities, prenatal care, and immunizations. The proportion of private sector dispensaries that reported delivering MCH services ranges from 16 percent of for-profits to 28 percent of voluntary agency dispensaries and 31 percent of parastatal dispensaries. Many family planning users, 23 percent,

obtain contraceptives from private sources, including VA facilities, private pharmacies, private clinics, and other private sources.

These data indicate that a more substantial portion of private health providers, especially hospitals and clinics, provide public health services than may have been apparent. While the relevant experience exists for private sector provision of these services, especially among voluntary agencies, data also show that the government has a large established capacity for key preventive and communicable services.

Determinants: What factors Affect Their Services?

The study looked at supply and demand factors affecting private health services. Supply factors affect the types and provision of services, and demand factors affect people's use of services.

Demand-Side Determinants

Despite being a poor country, there is a strong willingness and ability of Tanzanians to pay for privately-provided health services, both for-profit and non-profit. The competition among private clinics, dispensaries, and hospitals does not affect demand in Dar-es-Salaam but does affect demand for any given provider in the smaller city of Moshi. Although not studied, it is assumed that demand for private care increases with such factors as higher education, decreasing health status, aging, and publicity/promotion. Other factors are income, perceptions and real costs.

Income

Many people question whether a private health sector can flourish in a country where the majority of the population is relatively poor and may not be able to pay fees sufficient to sustain private providers. Even though average per capita income in Tanzania is among the lowest in the world (less than US\$200),

about 87 percent of the for-profit providers interviewed in this study said that their clients were willing to pay for health services. Another interesting finding was that the for-profit and non-profit providers informally assessed their customers' ability to pay and charged them according to this subjective judgement.

Perceptions

People's perceptions are critical to their choices of public or private services. The perceived "poor quality" of public services and the "better treatment" of private providers have greatly increased demand for private services, to the extent that private providers do not see public services as competition. Generally, private services are preferred to public services because of such positive features as better drug availability, more doctors' time with patients, higher staff motivation, less waiting time, more efficient and higher quality services, as well as other positive factors such as privacy, location, convenient hours, better equipment, and cleanliness.

Supply-Side Determinants

The greatest constraints on the supply of private health services are (1) lack of capital and access to credit (2) high taxes—especially on imported drugs and equipment, and (3) a critical lack of trained personnel—doctors, nurses, pharmacists, and technicians. There are other supply-side constraints including the following.

Legal Constraints

Over the last 25 years government policy toward private sector health providers has passed through several phases, from relatively open to legally prohibitive to the current period of re-liberalization. It also showed a consistent pattern in which the non-profit voluntary agency health providers operated in a more permissive environment than for-profit health providers.

Legalization has had a dramatic effect on the growth of the private sector in Tanzania, even with the attendant registration fees and taxes on profits. Under the liberalization provided by the 1991 Private Practice Act, there has been rapid growth in the number of for-profit hospitals, consulting clinics, dispensaries, maternity homes, and pharmacies all over the country, but especially in the major urban locations.

Regulatory Constraints

The regulatory environment has not kept pace with the rapid changes that have followed the 1991 law liberalizing the legal environment surrounding the private health sector. The inadequate regulatory environment is compounded by the general lack of qualified health personnel in Tanzania which constrains the smooth growth of both the private and the public health sector.

Financial Constraints

Availability of capital has been and remains a major constraint to the growth of the private sector in Tanzania, although the magnitude of this constraint varies by level of service and type of provider. Getting start-up capital has been more difficult for facilities categorized as for-profit than for non-profit facilities. The reliability of income from fees is closely related to the availability of start-up capital for private sector health providers. Many studies have shown that the existence of health insurance is one of the major factors associated with the potential for growth in the private health sector.

Under the 1991 Private Practice Act, all private health providers except non-profits are subject to business taxes and income taxes. As in virtually all countries, private providers in Tanzania perceive taxes to be excessive.

Linkages: What Links do They Have With the Public Sector?

Changing economic and demographic conditions have indicated to the government that its capability to develop, improve, and sustain free public health services has become limited. It is in this context that the Ministry of Health has considered and adopted several steps toward major reform of the organization, financing, and management of the health sector. Constrained public sector resources in Tanzania have made it increasingly important to look for non-governmental sources of funding for health services such as user fees, and for non-governmental sources of health care to help fill the gap between available health services and the health needs of the population. Since the early 1990s, the government has made private sector development a cornerstone of its health sector reforms.

In this reform effort, the MOH is encouraging private sector development in ways that can complement governmental provision of health services. This facilitating policy coincides with efforts to shift the role of government to include regulation as well as provision of health services. The change in posture toward the private sector has its roots in a recognition of current public sector financial constraints that make it necessary to look to non-governmental sources of health care and of the changing political environment.

As previously mentioned, liberalization of the laws concerning private providers has caused an explosion of for-profit facilities which now account for 42 percent of all private facilities in Dar-es-Salaam, including 83 percent of all private hospitals and 57 percent of all privately-owned hospital beds. The MOH has long recognized and taken advantage of the capacities of non-profit private providers, primarily church-based and voluntary agency health facilities. For example, the government incorporated 17 hospitals owned by non-profit voluntary agencies into the MOH health network as "Designated District Hospitals", or DDHs. Although these hospitals are still

owned by the voluntary agencies, they are now fully funded and directed by the MOH and so are generally considered to be public facilities.

Implications: What are the Opportunities for Improving Public Health and Private Provision?

Given the long history of collaboration between the public sector and non-profit private health providers in Tanzania, and given the wide distribution of non-profit providers throughout the country, the MOH should continue its strong collaboration with non-profit voluntary agency health providers to sustain their contribution to the general availability of primary care and hospital-based health services in the country. The major recommendations on improving the public-private collaboration are as follows:

- The MOH should continue to have somewhat distinct policies for each main type of private sector provider. In the past, the MOH has made a clear distinction between for-profit and non-profit health care providers. As the private sector continues to develop and to become more diverse, the MOH will have to further refine these policies to take account of the different practice patterns and financial orientation of such providers, and it will have to develop different incentives, regulatory approaches, and collaborative mechanisms.
- Given the current distribution of for-profit health providers, the MOH probably can concentrate its collaborative efforts with for-profit providers in Dar-es-Salaam, using that experience as a pilot for extension to other urban areas.
- The MOH should assess the potential role of employer-based health services in the private provision and/or financing of health services, as they might constitute a useful contribution to the capacity of the health system in urban areas.

- The public sector in Tanzania has a well-developed capacity and a good record for providing preventive services such as childhood immunizations. Given the public sector's strong comparative advantage in this regard, it makes no practical sense to shift responsibilities for these services to the private sector. The MOH should not, however, discourage those private providers who now deliver preventive services from continuing to do so, and it might selectively provide incentives to private providers to deliver preventive services where no public provider exists.
- The MOH should consider focusing on the private sector's capacity in curative health services at the hospital level as well as at the primary care level.
- With its long relationship with government and its provision of preventive services, the charity/mission sector offers the best chance for expanding

private preventive services.

- The government can create a more market-friendly environment by eliminating restrictive laws (hospital act), regulations (ownership requirement), and high taxes (drugs and equipment).
- Loan guarantees could improve access to capital, and training is needed for all types of medical professionals as well as traditional healers.

The main issue in public-private sector relations in Tanzania is no longer whether to collaborate, but how, and what forms of collaboration and incentives are most appropriate and cost-effective.

The government, providers, and donors need to reach a consensus on what is the private sector, its role, and government's relationship to it. The political and economic barriers are formidable, and a long-term strategy is needed.

Zambia: Private Providers and Public Health

Background

This summary is based on the DDM working paper entitled, Zambia: Non-Governmental Health Care Provision by Peter Berman, Kasirim Nwuke, Ravindra Rannan-Eliya, and Allast Mwanza. Please see the original document for complete details. The study conducted by DDM is an assessment of the role of “private providers” (private and non-government) in health delivery. On the supply-side, the study focused on private practitioners and government. The demand-side focused on consumers. The study was undertaken to address a major policy information gap in Zambia about private providers and their role in delivering health care.

Study Methods

The 1994 study was an extensive review of over 80 published and unpublished documents from numerous private, academic, government, and donor sources. In addition, the researchers analyzed many existing field data and clinical records, and undertook a small survey of providers.

The study focused on: (a) Zambia’s economy and demography; (b) private providers’ contribution to public health; (c) factors affecting the supply of and demand for private health care; and (d) recommended strategies for developing public/private linkages to support national health goals.

Characteristics: Who are the Private Providers?

The Ministry of Health (MOH) provides over two-thirds of Zambia’s health services. For the rest, 15 different types of

private providers were found—including hospitals, clinics, and specialty services provided by employers, particularly the copper mines; non-government organizations, mostly foreign church/mission services but also Islamic groups and national and foreign NGOs; and for-profit services which are mainly clinics, hospitals, pharmacies, drug stores, and such traditional practitioners as healers, spiritualists, and birth attendants.

At Zambia’s independence in 1963, there were few health services and health status was generally poor. In the next decade, the economy strengthened and health services grew and improved with heavy spending on public health. Now, however, the public system is over-extended, unevenly distributed, and deteriorating badly. Health spending and resources have declined in the aftermath of the mid-1970’s oil price shock, the collapse of copper prices, and macro-economic management problems. With these reverses, employment and income declined, poverty spread, and health status worsened as new and old drug-resistant diseases emerged.

Today, the government is committed to major health reforms, including new interest in the contribution the private sector might make to universal health. For the past 20 years, national policies had restricted private health services. Now, the political environment is more favorable and private for-profit services are growing. Private sector development may be essential because: (a) the government carries a heavy foreign debt and is overly dependent on donors to meet its obligations; and (b) there is a critical shortage of trained public medical personnel and training facilities and, ironically the public sector is most dependent on expatriate medical staff.

Services: What do Private Providers do?

The public sector health system includes those services that are financed or supervised by the MOH, including mission and industry (mostly mines) services. However, although they are subsidized, the missions only irregularly report their activities and there is great strain between the MOH and employer-based services. Moreover, the public system is not well coordinated with the private services of modern for-profit and traditional providers. But a major change did occur with the government's 1991 health reform which decentralized health-care management to the 36 districts, giving local responsibility for budgeting and management—including the purchase of local providers' services. Although the impact of the reform is not yet known, stronger ties may develop between public and private services.

Except for the missions and traditional healers, the location of both public and private services is biased toward urban areas and proximity to the railroads (line-of-rail)—this is particularly true of employer-based and for-profit services. So, although there are regional variations, more and better health services are in accessible areas of higher population and income and are concentrated in just a few of the nine provinces. For example, two-thirds of all health personnel, including doctors and nurses, are located in Lusaka and Copperbelt provinces, and 80 percent of all physicians work in four line-of-rail provinces.

MOH Services

Public services are organized in a pyramidal referral system of central, provincial, and district hospitals and village health centers. Although spread over the country, services are mostly in urban areas and along the line-of-rail. The number of facilities is high: 21 central, provincial, specialist, and other hospitals as well as 36 district hospitals and 1,037 health centers, which provide basic preventive and primary care.

Mission Services

Mission services are mostly in the rural areas, off the line-of-rail, and serve a poor clientele. Their locations favor the areas least served by the MOH. In some districts where the MOH does not have a hospital, the mission hospital serves as the district hospital. The missions run 29 hospitals and 53 health centers. And their staffing does not favor their central and urban facilities as do the MOH facilities. Also, some Islamic groups provide health care, and a non-profit NGO runs a Flying Doctor service.

Employer-Based Services

There are eight mine hospitals and four others run by the mines in districts without MOH facilities. And there are 66 plant and maternal-child care clinics. Most facilities are in the Copperbelt province and virtually all are in three provinces. The mines account for 20-25 percent of national health expenditures. Their services are high-quality and not constrained by funding or lack of staff. Also, other employers and parastatals provide about 130 other clinics, and they too sit along the line-of-rail. For the most part, mine and other industrial facilities serve only their own employees, and not the general public. Because of poor working conditions in the public sector along with private sector expansion, the number of industrial clinics is increasing.

Modern Private Services

Banned until recently, there are now two for-profit hospitals in the country. There are about 150 private clinics, which had never been banned. All fee-based services are in urban areas and along the line-of-rail, reflecting larger populations and higher incomes. The supply of private clinics is related to the supply of public doctors, as most clinics are staffed with personnel who also work for the MOH.

Pharmacies/Drug Stores

Pharmacies and drug stores are important sources of care in that about three-fourths (73%) of household health spending is on medicines. There is no exact count of their numbers, but they too cluster in urban and line-of-rail locations.

Traditional Healers

Healers are widely available in the rural areas, often the most accessible source of health care. There may be some 20,000 to 30,000 in the country.

Determinants: What factors Affect Their Services?

The study looked at supply and demand factors affecting private health services. Supply factors affect the types and provision of services; and demand factors affect people's use of services.

Demand-Side Determinants

Incomes and population densities are too low to support full-time, for-profit services in the rural areas. And because of high prices, private services in urban areas mainly serve higher income groups. Thus, over time and without intervention, private sector expansion will most likely reinforce the existing inequities of service access.

Income

Inflation has been high, real incomes falling, and living standards declining. Income is related to urban/rural residence, the presence of private services, and use of those services; and use of services is related to their prices and locations. Thus, although health status is low and the need for medical services is high, the use of private clinic doctors is low. By many standards, Zambians are generally poor and becoming poorer. And, at the same time, for-profit services are expensive. It appears that private sector expansion depends on long-term, sustained economic growth and an associated rise in household income.

Quality of Services

Studies find greater patient satisfaction with mission and private facilities than with government facilities. Technically, the quality of MOH services has declined with the decline in

health spending—and lower wages, reduced staff, lack of trained staff, unstable drug supply, and others. Perceptually, private providers are preferred to public services because of lack of qualified MOH staff, staff rudeness, low motivation, erratic supplies, lack of cleanliness, congestion, and others.

Education

At least for Oral Rehydration Therapy (ORT), level of education is related to awareness and use of private providers. It is assumed that increased health education could change consumer demand for other medical problems, promoting use of private services and promoting competition and better services among them.

There are no tax deductions or subsidies that might increase the use of private providers. And, although there are employer insurance/cost coverage schemes in the formal sector, they cover only about 6 percent of the population. Expanding health insurance to the informal sector appears to be limited by government's few resources, weak control, and inability to audit.

Supply-Side Determinants

While the economic and political climate now favors the growth of private health services, the greatest constraints on them are the lack of skilled human resources and access to capital and credit. Another constraint is government taxes, especially which are on imported drugs and medical supplies—most severe for pharmacists and for-profit providers.

Skilled Staff

All types of doctors, clinicians, nurses, and pharmacists are lacking, and especially in rural areas. The lack of doctors is most critical, because only they among MOH personnel are permitted to work (moonlight) in private clinics. As such, the total supply of private clinics is constrained by the supply of doctors. Since the 1970s, the ratio of doctors-to-population has been declining, as wages decline in the public sector. Zambia's medical school only produces about 40 doctors

per year—a number which is insufficient. At the same time, doctors are moving to other countries or into the private sector and the mines. Virtually no private doctors are shifting to rural areas.

Capital and Resources

The private sector is sorely constrained by lack of capital and available credit for investment. Accordingly, most clinics established in recent years have been industrial clinics, as large formal employers have easier access to credit. Even missions are allowed to charge hospital fees, but such fees and overseas donations cover less than 10 percent of their costs. As for other resources, use of technology is not high and access to it does not constrain private-sector development. On the other hand, MOH providers lack access to such basic supplies as surgical gloves, drugs, transportation, and others.

Linkages: What Links do They Have With the Public Sector?

Health providers work in a government regulatory environment, which includes personnel licensing and facilities registration. But, other than ensuring that basic legal requirements are met, the government has little capacity to regulate medical practices, fees, or market structure. While the MOH is supposed to supervise health services, the public health system is not well coordinated with the private system, especially for-profit providers and traditional healers. There are few fora for organized public and private communication. Access to public policy-making is on an individual, not institutional, basis.

Employer services are legally government-owned but they, notably the mines, are financially self-sufficient, have access to foreign exchange, and operate autonomously—with mounting strain as they expand and MOH services contract. Although their reporting is sparse, the missions are most integrated into the public system, as they are largely publicly financed through bed and staff grants and seconded personnel. But, overall, public/private oversight and informa-

tion linkages are weak. With decentralization, coordination of private and public services may improve through the closer local (district-level) relationships that exist. Moreover, policy-makers have new interest in the potential of the private sector, including traditional healers.

Implications: What are the Opportunities for Improving Public Health and Private Provision?

There is not enough information in Zambia to assess the role of private providers or their potential for improving public health. Private providers are not homogeneous in structure, fees, composition, output, or location. They vary as well in their susceptibility to government leverage. Different policies will be needed for different providers.

Overall, the public health system is high-cost, yet unable to provide equitable access to care or to prevent deterioration of national health status. Skilled human resources are too few and public facilities are too many to be supported in peripheral areas. Staff and services are heavily concentrated in urban and line-of-rail locations. Decision-making is over-centralized, and unable to respond effectively to health needs. To improve the health system, policy-makers face the challenges of improving: (a) availability of resources; (b) efficiency of resource use; (b) equity of access; and (d) effectiveness of services.

Recommendations for increasing public/private linkages and their shared contributions to improve national health fall into three categories: general policies, specific providers and specific services. Better information, training, and reporting cut across these categories.

General Policies

To increase the quantity and quality of private providers' contribution to public health requires reducing constraints on their actions and improving government's

ability to coordinate them. The government should continue its decentralization of health decision-making; relax restrictions on private practice by MOH staff, but enforce rural residency requirements; enforce annual licensing and tie licenses to data reporting; and increase numbers of qualified professionals through educational reforms.

Specific Providers

Different actions are needed for different providers, for example:

- Missions: The government can encourage mission services in rural and poor areas with a grant scheme weighted in favor of such areas;
- Mines: As long-term growth of the health sector depends on a revitalized, profitable mining sector, government can encourage privatization and contracting mine-provided health services for non-mine populations;
- For-profits: government can encourage expansion of non-subsidized private ambulatory care, but not for-profit hospitals; and
- Insurance: Private insurance and employer-based services can be encouraged without subsidies, tax exemptions, or tax deductions;
- Pharmacies: MOH should be a major supplier of pharmaceuticals to keep prices down in the private sector; and
- Traditionals: Training of TBAs would improve their

integration into the public referral system.

Specific Services

The report concludes with a series of policy recommendations for urban and rural areas that would (a) increase the overall supply of population services, drugs, primary health care, and hospital services; and (b) increase private sector contributions to specific problem areas—maternal conditions, EPI diseases, tuberculosis, malaria, diarrheal diseases, and HIV/AIDS.

At this point in time, private providers under-provide preventive services and services of public health importance. With good policies, the growth of the private sector can enable the MOH to divert resources to the deprived rural areas, thus increasing both the level of private provision and the availability and equity of public services.